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# Lived Experience of Women Veterans Navigating the Veteran Healthcare System

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This is to certify that the doctoral dissertation by

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Abstract

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## Abstract

Many women veterans who navigate the Veterans Affairs (VA) healthcare system across the United States have felt that their voices have not been heard regarding their input and lived experiences concerning inclusion to the quality-of-care delivery for their health needs. The purpose of this study was to explore the lived experiences of women veterans who were currently facing or had previously faced difficulty navigating the VA healthcare system. The framework used for this qualitative study was interpretive phenomenological analysis. The qualitative method used was hermeneutics which was designed by Edmund Husserl and Martin Heidegger. Semi structured interviews were of 12 women through the Zoom platform, who met the sampling criteria as a veteran and receiving services from the VA within the Washington DC area. The data was analyzed using the thematic method which emerged 10 themes addressed the study research questions. The participants reported there were biases towards women when receiving care, lack gender-based services, lack of appointment times and decline in overall health from interactions with the VA medical staff. The study findings further revealed that there are still gaps in health treatment and resources in connecting women veterans to proper healthcare within the VA healthcare system. The findings may assist the VA leadership in aligning patient-centered practices with appropriate quality care for women using proper needs assessments, medical staff empathy, and communication to provide better standards of care and equity for all veterans, especially women veterans.

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# Dedication

I would like to thank all those individuals who encouraged, prayed for, and motivated me. I am dedicating this to my family and friends who have been my rock over the years to stay the course and finish this journey.

This dissertation is dedicated to my mother, who died when I was 18 and just starting out on my academic journey. She always wanted me to do extraordinary things with the gifts that I had. I would be remiss if I did not also dedicate this to my special aunts who have always been my guiding light since my mother died.

I would like to thank the DC area veteran community for the knowledge and the vow to continuing this work in the community. Next, I want to thank Dr. Joan Gordon. She has only been in my path for a few years, but within the those few years, she saw something that no one could; she has been a great mentor even when she thinks I am not listening.

Finally, I thank God for giving me the blessing, strength, and will continue even when I thought I could not physically and mentally complete this task, which gave me the inspiration within me to do this work.

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# Chapter 1: Introduction to the Study

## Introduction

The Department of Veterans Affairs (VA) is the most extensive healthcare system in the United States. It is responsible for providing healthcare services to all men and women who have served in the U.S. military (Brooks et al., 2016). As of 2020, there are 23 million veterans who have served in the military, but only 2 million are women, and only 6.5% of those women veterans seek care and services from the VA (Devine et al., 2020). While the number of women enrollees is increasing, the VA, specifically the Veterans Health Administration (VHA), has made some improvements and pursued initiatives to increase women veterans' quality of care (Women's Health Services, 2018). However, the VA has had and continues to have a challenging relationship with women veterans due to the male-centric culture and stigma embedded within the organization. This barrier has made women veterans feel uncomfortable receiving care or resources from the VA due to disparities in care compared to male counterparts (Mattocks et al., 2020).

Recent studies have highlighted some changes regarding women's health services for a more integrative health experience. However, the male-centric military culture has continuously influenced VA healthcare (Moreau, 2020; Muirhead et al., 2017). In contrast, some women veterans have sought healthcare outside of the VHA while using private insurance due to the perception of the VA's lack of access to quality care for women veterans. Furthermore, the Choice Act passed by Congress opens options for veterans seeking care outside of the VA and gives more options for services, especially

for women veterans (Kehle-Forbes et al., 2017). Other data have shown that women veterans report poor health in general and high risk for chronic disease, health risk behaviors, and mental health conditions due to exposure from serving in the military compared to civilian women (Mankowski & Everett, 2016). These issues have influenced the VA in developing and evaluating targeted treatments for women veterans (Lehavot et al., 2013).

Historical context regarding the male-centric system of the VA can aid in understanding the current barriers that women veterans face. Many women have a different path and outlook in the military due to the sexist subculture and differential treatment of women within military healthcare (Hirudayaraj & Clay, 2019). This male-centric culture has overshadowed women, their challenges, and their healthcare needs and has caused barriers with the VA (Muirhead et al., 2017). These stressors have caused veteran women to experience adversity while becoming reaccustomed to civilian life and may discourage women transitioning from the military from seeking healthcare services or resources from the VA (Maiocco & Smith, 2016). For example, many of these stressors are caused by military sexual trauma and related traumas. While serving in the military, at least 40% of women veterans have reported trauma to VA and military providers (Burkhart & Hogan, 2015). These incidents of military sexual trauma and the aftereffects carried over into VA healthcare have caused barriers to the quality of care.

VA data show an increase in mental health diagnoses and indicate that 52% of veteran women receive musculoskeletal diagnoses within the first year after active-duty service (Goulet et al., 2016; Haskell et al., 2011). However, the male-centric

organizational culture has left gaps in services provided to women veterans due to differences in clinical presentation or staff's inability to properly diagnose women (Women's Health Services, 2018).

This study entailed interpretive phenomenological analysis (IPA) of women veterans and their lived experiences with the VA healthcare system. Women veterans have a history of barriers to receiving care from the VA identified through past and current research from multiple sources, including the VA (Marshall et al., 2021; Mattock et al., 2020; Resnick et al., 2012; Yano et al., 2003). This study has the potential to help women veterans educate themselves on their healthcare needs and advocate for their care. Additionally, the outcomes from this study may assist the VA in understanding the experiences of women veterans to shape a better quality of care through organizational culture change. According to the Institute of Medicine (IOM, 1990), for patients, quality of care measures the degree to which access to health services for a population increases so that members of the population may receive better health outcomes and knowledge of health. The gaps that correlate with women veterans' lack of quality of care compared to their male counterparts, which include not having the same access to services, lack of sensitivity, and treatments, are barriers to healthcare for women veterans (Vogt et al., 2006; Yano et al., 2010).

## Background

The VA has well-documented data highlighting that women veterans' gender-specific services lag those of their nonveteran counterparts regarding healthcare needs and access to quality care. The barriers to utilizing VA healthcare for women include

access to mental health, integrative medicine, and VA community care (Newins et al., 2019; Thomas et al., 2018). Women's perceptions of the VA culture regarding women veterans have created stigma and led to women seeking care from other healthcare systems using private insurance (Newins et al., 2019; Rank & Heroux, 2018). According to Resnick et al. (2012), the VA has implemented many changes and added new services and programs for women veterans; however, eligible women are still not getting proper care. Women feel uncomfortable with the organizational culture of the VA due to the staff's treatment of them. Women veterans have increased in population, but there is still underutilization of VA healthcare among them (Brunner et al., 2019; Yehia et al., 2017). The disparities women face while navigating the VA system have identified other social determinants of health, such as access to specialty care services or access to specific women's health clinics that are not available in many of the VA Medical Centers nationwide (Montgomery et al., 2020; Washington et al., 2011). The most prevalent documented disparities involve chronic disease management, inpatient care, and patient experience of care (Than et al., 2020). However, women veteran populations have been more likely to seek health education and visit their primary care doctor for preventive measures within VA healthcare than veteran men (Etingen et al., 2020).

Furthermore, those gaps have correlated with VA staff's readiness to work with the women veteran population. Some VA providers have no experience working with women veterans and their unique needs, which has caused the disparity gap to widen (Than et al., 2020; Yano et al., 2014). The VA's organizational culture has caused staff to contribute to continued gender biases that affect access and care quality for women

veterans, leading women to feel isolated and uncomfortable seeking care (Brunner et al., 2019). Staff perceptions have shown lack of empathy and compassion regarding gender-sensitive healthcare for women's unique needs (Evans et al., 2019).

## Problem Statement

The VA is the most extensive integrated health system in the United States, providing comprehensive care to almost 9 million veterans; however, women veterans make up only 7.5% of the VA health population, compared to 19% of the total veteran population (Bialik, 2017; Kehle-Forbes et al., 2017). Historical data show gaps in care access for female veterans compared to male veterans (deKleijn et al., 2015). The research highlights gaps in addressing women veterans' health disparities while navigating the healthcare system, specifically within the VA. The VA is a male-centric system that does not provide equal access to women veterans and fails to meet the health needs of women who have served in the U.S. military (Costenbader & Winstead, 2018). Because the military has expanded resources for women veterans, the VA will need to provide more services to meet their specific needs (Carter et al., 2016; Newins et al., 2019).

According to Washington et al. (2015), there remains a lack of knowledge and representation of some services, inconveniencing women veterans seeking care from the VA. Mattocks et al. (2020) suggested the importance of maintaining the quality of care for women veterans and not further discounting women's health-related symptoms, medical concerns, and personal preferences in addressing their health issues. Kehle-Forbes et al. (2017) state that women veterans in the VA system have discontinued their

healthcare because of the perception that staff are unwelcoming and lack of cultural competence to provide proper care to women and men veterans. Women veterans may have some exposure to trauma-related incidents such as combat, like their male peers (Yano & Hamilton, 2017). However, women veterans are at a higher risk of sexual trauma, adding another layer of psychological modalities. These negative experiences in the military continue the trajectory of adversity that further magnifies the risk of harmful health effects in women veterans (Yano & Hamilton, 2017). By using IPA to understand women veterans' lived experiences, I sought to understand better how women veterans navigated the VA in the Washington, DC area.

## Purpose

Using IPA, I aimed to understand the current health education system and resources to assist women veterans. Furthermore, women veterans' lived experiences can help shape future health education programming within the VA. These lived experiences can help more women veterans obtain tailored healthcare services from the VA (Weitlauf et al., 2020). Existing studies suggest that the VA has improved primary care for women veterans but has not expanded specialty care needs that may result in continuity of care (Mattocks et al., 2020). This proposed study can help VA providers understand women veterans' health experiences, quality of health services, mental healthcare, and military sexual trauma-related care.

## Research Questions

RQ1: What are the lived experiences of women veterans navigating the Veterans Health Administration?

RQ2: What is considered quality care from women veterans' perspective when receiving care from the Veterans Health Administration?

RQ3: What are the reasons women veterans do not receive or stop receiving health services from the Veterans Health Administration?

## Theoretical Framework

In this study, I used IPA and gender equity theory to understand women veterans' lived experiences while navigating through the VA healthcare system regarding equitable care outcomes. Researchers using phenomenology aim to understand individuals' everyday experiences by uncovering participants' perspectives. This framework has embedded story theory that guides the gathering of lived experiences and uncovers themes from the participants' stories (Maiocco & Smith, 2016).

IPA is an approach in hermeneutics. Edmund Husserl and Martin Heidegger coined the primary concepts of phenomenology concerned with attending to the way things appear to individuals in their experience (People, 2020; Pietkiewicz & Smith, 2014). Understanding the human lived experience through an unbiased viewpoint allows a researcher to conduct phenomenological studies (Horrigan-Kelly et al., 2016). When applying IPA, the researcher gathers data and information by removing preconceptions and biases while also understanding the participants' lived experiences. For example,

applying IPA in this research study helped in understanding women veterans who have difficulties navigating and receiving care provided by the VHA.

## Nature of the Study

Phenomenology research gives the perspective of understanding the world through openness and restraining oneself from using predispositions about a specific stance, letting the lived experience guide inquiry (Finlay, 2008). The environment and social circles shape people's realities. The researcher identifies these experiences linked to cultural norms that affect how people think and how decisions are made from the participant's view instead of forming researcher biases (Tuohy et al., 2013). Furthermore, interviewing women veterans about their experiences of a phenomenon can help in developing health education and communication to improve health literacy by understanding women veterans' unique health needs and implementing proper programming around those lived experiences. The participants' experiences showed how navigating the VA system had affected their healthcare in Washington, DC area VA healthcare centers.

## Definitions

*Women veterans*: Women who have served in the U.S. military in active duty, Reserve, or National Guard status.

*Health disparities*: Health differences that affect a population and are closely linked with economic, social, and environmental disadvantages (HealthyPeople.gov, 2020).

*VA eligibility*: Applies to an individual who served on active duty or Reserve/Guard for at least 24 months of service in any branch of the U.S. military, or who had a service-connected injury that occurred during their military service and resulted in an honorable discharge. Such a disability that affects daily life functioning is eligible for care under the VA (U.S. Department of Veterans Affairs, 2020).

*Gender bias*: Unintended or systemic neglect of one gender due to stereotyped preconceptions about health, behaviors, and experiences that hinders individuals of that gender from receiving quality care (Hamberg, 2008).

*Veterans Health Administration (VHA)*: The VHA is part of the Department of Veterans Affairs. This entity provides health benefits and care to individuals who have served in the military and have a service-connected injury (Winters-Miner et al., 2015).

*Behavior change*: Adjustment of behavior, which affects a patient's view and may occur through operant conditioning (American Psychological Association, 2021).

*Military sexual trauma*: A term used for sexual assault and harassment that occurred during military service (U.S. Department of Veterans Affairs, 2021)

*Health education*: A social science that involves educating and promoting public health in all aspects and enhancing quality of life for all individuals.

*Community-based outpatient* clinics: The VA has implemented over 800 outpatient neighborhood clinics to make it easier for veterans to get certain types of care. These clinics are heavily implemented in rural locations away from larger VA medical centers (The American Legion, 2020).

*Hermeneutics*: This interpretive process involves pursuing understanding and disclosing a phenomenon by finding meanings in individuals' lived experiences.

*Quality of life*: Present when individuals are healthy, functioning, and comfortable doing events and remaining active while performing daily routines (Hays & Reeve, 2017).

## Assumptions

Using a qualitative approach was appropriate for collecting information from women veterans who had experienced navigating VA healthcare. With this approach, I assumed that the participants were transparent and open regarding their experiences and sought to make them feel comfortable talking about their health, which probably started within their military career until transitioning out the military as a veteran to their interactions with VA. The assumption that all women veterans are experiencing the same types of treatment or disparities was a perceived bias that did not guide this study. As the researcher in this study, I sought to examine the lived experiences of veteran women and gain insight into how to influence change in the VA healthcare culture.

Second, to resolve biases in this phenomenological study, I sought to develop a space of neutrality for the participants by gaining their trust and understanding their life-world experiences (Suddick et al., 2020). Finally, the women veterans sought out for this study were VA eligible, meaning that they had served in the military, received an honorable discharge, and had a service-connected disability.

## Scope and Delimitations

The participants were women veterans living in the District of Columbia and surrounding areas, including Maryland and Northern Virginia. They were recruited through veteran service organizations, women veteran support groups, and community engagement efforts within the veteran community. Using the snowball effect, recruitment occurred through flyers, social media announcements, and emailing women veterans currently in the local veteran network. Participants also told other women veterans about this study.

These participants consisted of women veterans who currently got their care or had sought care in the past through the VA. Using the IPA approach and gender equity theory to capture the health experiences of women veterans navigating the VA was the best option for this study. These women veterans' identities were kept in confidence, and I provided each participant a pseudonym. I conducted semi structured interviews for approximately 45 to 60 minutes, using Zoom as the meeting platform (Appendix B). The virtual platform allowed recording the interviews, with transcription completed separately using Zoom and Rev transcription services. These services kept data organized and helped me create themes from the interviews.

## Potential Limitations

The requirement to conduct virtual interviews due to the current public health pandemic was a study limitation. Unlike face-to-face interviews, which allow the interviewer to read nonverbal cues, interviews that occur on virtual platforms are not as personable (Vining et al., 2020). The second limitation was interviewing veterans in

Washington, DC, and surrounding areas, limiting the range of perspectives due to focusing on a particular area for veteran recruitment. Third, I relied on the honesty and transparency of women who identified as veterans who had served in the U.S. military and had a disability rating from the VA. Lastly, the topic of health was a sensitive topic for many individuals; women veterans are a population whose members face challenges with gender-specific services for their unique needs (Newins et al., 2019).

## Significance

Women veterans do not have primary care options under the current VA Public Law guidance. This guidance focuses on women veterans' healthcare matters for the VA (U.S. Department of Veterans Affairs, 2015). It addressed updated issues such as access to resources, care equity, and program implementation for women veterans' health in VA Public Law 111-163. This study aimed to understand how women navigate the VA, apply lived experiences to address inequalities in access to care, and implement future health education efforts. However, change within VA healthcare should involve those women veterans who feel they are being undervalued and receiving care of subpar quality due to the organizational culture. Current data show that women veterans are open to changing the VA environment by increasing female employees, improving the male-centric climate of the VA, and addressing women veterans' sensitivity and health needs (Moreau et al., 2020; Vogt et al., 2006). Positive social change promoted by this study may include changing the organizational culture of the VA through insight from women veterans and educating VA healthcare staff about changing behaviors that can be viewed as unwelcome to women when assisting with their healthcare needs. Through this study, I

sought to provide insights to change organizational norms and align those initiatives to provide quality care and resources within an environment welcoming to women veterans. This research study may inform intersectional integrative care initiatives and education through elucidating specific experiences of women veterans concerning quality care through the VHA.

## Summary

Women veterans have been essential to the U.S. military defending the country for decades. However, as they transition into the veteran community, women veterans do not have equal healthcare resources compared with men veterans due to lack of services. The VA system needs women's health services nationwide in every VA Medical Center, like women's health clinics. Second, the VA has implemented some changes to make the organization less male-centric and has tailored health services and care for women veterans (Evans et al., 2019). However, those changes have not made women veterans feel welcome in getting their healthcare through the VA.

Studies have highlighted the barriers to quality of care and the potential to bridge the gap between the VA and women veterans. In contrast, this study focused on hearing the lived experiences of women veterans who have navigated the VHA. This study highlights the gaps between veteran women and health equity with services provided by the VA. Chapter 1 provides the introduction to the study, including the premise for the study, the problem statement, and the exploration of the complex phenomenon regarding women veterans' experiences with the VHA. Chapter 2 will expand on the theoretical framework and contain a literature review of past studies highlighting women veterans'

health needs, resources, and the correlation between VA healthcare and the perceived organizational culture.

# Chapter 2: Literature Review

## Introduction

The aim of this IPA study was to understand women veterans' lived experiences and how those experiences can improve the quality of care received from the VA. In this chapter, I discuss historical data, gender disparities, and studies of women veterans' barriers to receiving healthcare from the VA. The lived experiences of women veterans and their unique needs within the military and veteran communities give insight into how to provide quality care and resources to women who have served in the U.S. military.

The VA is an integrated health system providing care to nearly 9 million veterans (deKleijn et al., 2015; Ross et al., 2015). However, there remain gaps in services and access to care for women veterans. Historically, the VA has been considered a male-centric system. Therefore, there is an existing gap for women veterans to access the same services level as male veterans (Costenbader & Winstead, 2018). Despite in-depth research studies that have examined the VA health system and the imbalance of services offered to women, there continue to be barriers to women veterans accessing specific care and services (Brooks et al., 2016). Women veterans are apprehensive about acquiring healthcare services from the VA. In some cases, they pursue other healthcare services as there is a lack of quality of care due to gender sensitivity (Bean-Mayberry et al., 2011). Even though services such as women's clinics have been added to many VA medical centers around the country, specific access barriers for women veterans keep this population from getting care within the VHA.

Furthermore, in conjunction with the lack of services, Montgomery et al. (2020) showed that women are in the minority when addressing access because of pre-existing factors such as experiencing trauma. Some trauma stemming from their military career affects women veterans' outlook on seeking resources from the VHA (Moreau et al., 2020). Women veterans should have the same access to care as their male counterparts. However, to get a certain level of care, women veterans must use a mix of VA services and community providers for their unique needs (Silvestrini et al., 2020). Women veterans' lived experiences can bridge the gap within past studies to better understand the disconnect between the VA and women veterans. Within this chapter, I discuss the literature search strategy for this inquiry; the theoretical framework, which includes IPA and gender equity theory; the historical context of the relationship between women veterans; and VA healthcare.

## Literature Search Strategy

I conducted literature searches regarding women veterans and their barriers to care within the VHA. The searches provided historical data that capture the progression and disconnect between the VHA and women veterans. The research used in the literature review was acquired using the following databases and resources to support the study: Walden Library website, Google Scholar, Department of Veterans Affairs, and Center for Women Veterans reports and research studies. Other databases searched were PubMed Central, EBSCOhost, Med Care, Women Health Issues, Sage Journals, and Science Direct. The main keywords used in searching the background of the VA and the relation to women veterans included *women veterans, female veterans, quality of care, gender*

*bias in Veterans Health Administration, women services, military sexual trauma, deployment, health disparities, mental health and veterans, disadvantage, barriers, gender differences,* and *lived experiences.* I used search words and studies that aligned with the topic and studies conducted between 2005 and 2020; some studies encompassed historical context, the origination of the VA, and inability to access healthcare services for women veterans. The literature search criteria encompassed various VA reports and previous studies highlighting the gaps and stark differences in women's services within the system and the staff's organizational culture and mindset about treating women veterans. While these studies have addressed the disconnect between women veterans' needs and the VA, few have captured women veterans' lived experiences of their perceptions of and barriers to care access.

## Theoretical Foundation

In this study, I used the IPA framework to understand the lived experiences of women veterans navigating the VHA, either currently or in the past. Phenomenology is a qualitative inquiry with many different interpretations and strands of understanding live world experiences that may have deeper meanings. The following section details hermeneutics, another name for IPA. In this phenomenological research, I sought an understanding of a phenomenon. Rather than using a conceptual or theoretical framework, this study used the philosophical framework (Peoples, 2020).

Furthermore, IPA is described as a theoretical framework because it reflects the systemic examination of living within an experience (Wagstaff et al., 2014). While IPA is ordinary in health psychology, IPA expands to studies in the healthcare research field

used for patient care and education (Biggerstaff & Thompson, 2008). In order to understand this research study, it is necessary to understand the foundation of phenomenological theory in the work of philosophers Husserl and Heidegger. Husserl's philosophy involved personal experience in which other frameworks may not study a particular phenomenon because it would be impossible to get to the core of understanding real world views (Byrne, 2001).

**Edward Husserl**

Husserl is considered the founder of phenomenological philosophy, which was developed to understand the human experience that seeks knowledge of consciousness in research regarding a phenomenon (Suddick et al., 2020). As a philosopher, Husserl identified themes within phenomenology research such as intentionality, reduction, horizon, and the researcher's bracketing (Peoples, 2020). In addition, Husserl's viewpoint represents an individual's viewpoint that inserting real world views in research. (Kern, 2019).

**Martin Heidegger**

With the guidance of Husserl, Heidegger, his protégé, became a phenomenological philosopher. However, Heidegger's philosophy furthered phenomenology by creating hermeneutics, which began with "life-world" experiences while suspending perceived judgments and observing a phenomenon (Herskowitz, 2020). When analyzing people, Heidegger viewed life experience from a human totality perspective, addressing how humans are not subjects and understanding the relationship humans have with objects and other people (Campbell, 2019).

**Hermeneutics and Phenomenology**

Within this study, IPA was a qualitative approach used to investigate a specific phenomenon through the use of interviewing as a data collection method (van Manen, 2017). Phenomenological research was coined by Husserl and focuses on the use of IPA to examine actual experiences, whereby the researcher must use interpretation to investigate theoretical context (Wagstaff et al., 2014). Husserl's philosophy involved studying a phenomenon and eliminating biases when researching "a thing." Han thinking is linked to something that shapes how individuals process their lived experiences (Peoples, 2020). Furthermore, Heidegger adopted Husserl's phenomenological philosophy, building on Husserl's theory. However, he took it a step further with hermeneutics, which focused on life-world experiences and how those experiences can be used to understand a phenomenon (Laverty, 2003).

Heidegger's concept of IPA involves exploring a person in each moment to bring sense to a phenomenon. The person actively participates in understanding their view of a subjective world or experience (Wagstaff et al., 2014). In order to implement IPA successfully, there should be a place for bracketing. Bracketing is used to put aside researcher influences and biases to ultimately be open to a complete interpretation of people's meaning of their experiences (Tuohy et al., 2013). Addressing bracketing leads to a fore-structure that is one of IPA's core concepts because it focuses on the preconceptions of a live-world phenomenon under inquiry (Dahlberg & Dahlberg, 2020). According to Husserl, bracketing allows the researcher to be a stranger to a specific phenomenon, giving the researcher a fresh view of an experience (Peoples, 2020).

Building on Heidegger's philosophy, Paul Ricoeur bridged phenomenology and hermeneutics with his approaches starting in 1976. He applied inspiration to interpret data and understand purpose through a person's world experience (Simonÿ et al., 2018).

**Gender Equity Theory**

Gender equity theory originated from the World Health Organization (WHO) when addressing health equity while adding gender as a component. Gender equity theory formally has justice and equality between genders when addressing social and health constructs (Walton & Schbley, 2012). In this research study, I explored women veterans' inequities and disparities in obtaining gender-specific health services through the VA. The VA culture has demonstrated inequitable treatment of women veterans compared to their male counterparts (Zickmund et al., 2018). Gender equity theory served as one of the lenses to understand the inequity of healthcare access for women veterans. The research captured the lived experiences of women veterans and how they perceive inequalities related to healthcare services (Mattocks et al., 2020).

According to Bevans and Clayton (2019), continuing to have the focus of future clinical research be women veterans, the fastest growing population to engage within the VA, can help change the culture. This culture change may include health behaviors, participating in health promotion programs, and advocating with the medical team to bridge health disparities. Although the VA has improved some standards to deliver better healthcare services to women veterans, there are barriers to healthcare services more readily available for men. Gender equity has improved through some VA efforts, such as creating the Office of Women Veterans, but the system needs to change to care for

women veterans. Barriers still exist, given the limited availability of gender-trained providers and onsite gender-specific services specifically affecting women (Marshall et al., 2021).

Healthcare gaps regarding women navigating the VA are complex but exploring those barriers can bring some understanding of the root cause of the problem. According to Devine et al. (2020), given many of the barriers, such as depression, the unique quality of life that stems from military culture, and the VA system's inexperienced nature, women veterans are at a disadvantage compared to men veterans seeking the same care and services. Furthermore, Lehavot et al. (2019) found limited research regarding women veterans regarding disparities they face when addressing health concerns that intersect with gender within the VA culture. The overlapping vulnerabilities with the prevalent women veteran population relate to more service-connected injuries and mental health diagnoses, but other areas of care are severely lacking (Lehavot et al., 2019).

## Literature Review

This literature review section addresses additional gaps between women veterans and the VA. The historical context sets the foundation for how VA healthcare gaps began, leading to many health disparities and inequities that women veterans have faced since the VA Health Administration opened access to health services women veterans in 1983 under a Congressional mandate for VA to provide quality of care to women and not just men. Second, the section highlights some of those health disparities due to resource availability and congressional support of policies and regulations that are in place to bridge the gap between women and the VA.

**Historical Context of Women Veterans**

In 1980, the first census was taken of women veterans and women serving in the military. More than 1.2 million women stated that they served in the military (U.S. Census Bureau, 2020). Upon this new information, there were efforts to target and educate women about their benefits with the VA. Furthermore, after studies were concluded in 1982, it was found that women did not have equal access to VA services, gender services such as obstetrics and gynecology (OBGYN) were unavailable, and women did not receive complete physical examinations due to the lack of staff understanding women's health. These actions led to the Veterans' Health Care Amendments of 1983, including the establishment of women veteran advisory committees (Yano & Bastian, 2011).

The VA adopted a comprehensive model that implemented women's clinics in a few VA medical centers nationwide. However, clinics were taking on the bulk of integrative medicine just for women veterans. These clinics were more likely to have same-gender providers and staff to meet the needs of women. This study highlights that while these clinics changed the VA's culture, some barriers, and challenges women veterans face outside the women health clinics (Yano et al., 2003). According to Washington et al. (2006), the VA implemented programs geared to serving women veterans as they continue to report receiving services and comprehensive care from the VA. However, Washington et al. found that many women, misinformed regarding services at the VA, did not know if they were eligible for services, did not understand the

quality of care from the VA's representation, and perceived going to the VA as inconvenient as because it was often too far from their residence.

**Women Veterans' Health Disparities**

In this section of the literature review, I outline the gaps in the research regarding women veterans, the different types of studies conducted in the last few years that address research barriers, and how the relationship between the VA and women veterans has caused health equity and support issues. As part of this study inquiry, I sought to understand the historical context and gaps between the VA and women veterans in relation to receiving equitable care and how the research can align with the lived experiences of women veterans.

Washington et al. (2015) examined the VHA, care delivery, and the unique relationship with women veterans from 2008 to 2009. Of the initial mailing of 10,638 surveys, only 6,454 women participated in the survey, of which all were eligible for VA benefits. Washington et al. (2015) discovered access and gender-related barriers in the following areas: appointment times availability, access to prescriptions, and women's health clinics in the serving area. It was found that women veterans perceived that community-based healthcare had more flexibility and cost-effective service offerings than VA healthcare. Brooks et al. (2016) found that women's views of the VA were from past experiences and the perception of how the VA does not cater to the women veteran population. Those services' difficulty, coupled with distance, caused women to seek care from a community clinic closer to their homes. However, from the VA's standpoint,

medical advances have occurred in delivering care to women veterans (Yehia et al., 2017).

The most common reasons for seeking care outside of the VA were insurance and the participant's location. Many participants did have dual insurance. They received care from the VA and had private insurance, forcing women veterans to seek alternative care from providers not equipped to deal with their unique needs (Moreau et al., 2020). These details gave more information and viewpoints from the women veterans who could compare care differences (Muirhead et al., 2017; Washington et al., 2015). Furthermore, Di Leone et al. (2016) argued that the women veterans' identity has created barriers to the VA's cultural norms. These barriers have contributed to women being uncomfortable receiving healthcare services and resources from the VA. Buckhart and Hogan (2015) stated women's pre-existing conditions of past abuse that transpired in the military, identifying that women veterans have unique healthcare needs while serving in the military and that those types of services should be available post military within veteran healthcare.

Di Leone et al. (2016) explored women veterans' identity and why it shaped how the military influenced societal norms, including the veteran community. The researchers' purpose was to bring attention to veteran women and their needs for healthcare due to historical barriers in health research within the VA system. The uniqueness of women's health needs correlates with the VA falling short of providing such care because many women do not want to use the system as part of their healthcare treatment. The VA has since partnered with community organizations to identify

women's needs, which has helped develop research, interventions, and programming targeting women to get their care and resources through the VA (Mankowski & Everett, 2016).

In response to these challenges, the VA has implemented a more transparent screening for women veterans who experienced health barriers, including long wait times for an appointment and the lack of understanding/relatability with the VA providers (Newins et al., 2019). Due to these perceptions, some women veterans prefer to use private insurance and receive their care outside of the VA. While there are known persistent gaps between the VA and women veterans, there needs to be a behavior change and diversity amongst the VA staff (Than et al., 2020). Many of the inequalities are documented throughout current studies in the last few years after implementing women-specific programs such as the women's health clinic in many VA medical centers across the nation (Brooks et al., 2016). Breaking the barriers to SDH and gender gaps can potentially welcome women veterans to the organization for their health needs. In response to these challenges, the VA has implemented a more transparent screening for those veterans that have experienced social determinants of health barriers.

**VA Organizational Culture**

Moreau et al. (2020) explored the organizational culture through the perceptions of women veterans within this study to understand the barriers with the VA and how those experiences can change the culture for women to get better standards of care. Dyer et al. (2019) reported that women veterans still feel unwelcome seeking healthcare services from the VA due to multifaceted factors such as carried-over attitudes from the

male-centric military culture, military sexual trauma, or another traumatic encounter while serving in the military. Women veterans felt resources and care should be separated and private. The VA leadership can potentially invest in more diverse hiring, including female medical providers and clinical support staff, and changing the hospital environment (Moreau et al., 2020).

Public harassment in medical settings is rare but does occur in the VA. Klap et al. (2019) stated that most of the women harassed in the VA environment by other guests were under 45, and the behavior caused women to miss or delay their medical appointments. When it occurs in the VA environment, where many women have experience MST from active duty, the dominating male population in these settings has attributed to women feeling unwelcome and unsafe. The VA should minimize guests, especially men that display disrespectful behavior to other guests as they enter the VA centers. In addition to making women feel unsafe, this behavior may damage other guests moving about the hospital. There is no clear explanation for why several VA centers allow guests to congregate in the lobby to harass women veterans entering the facility to obtain services (Dyer et al., 2019).

The VA environment has been labeled a male-dominated setting characterized by trauma cues. The VA patient population is comprised of primarily male patients who share similar military sexual trauma behavior traits (Gilmore et al., 2016), which contributes to the harassment of fellow veterans who are women when entering and exiting the VA medical centers. According to Klap et al. (2019), this harassment and the inadequacy of services to women added to their reluctance to obtain care from the VA.

The VA findings supported the change in the design to alleviate this issue but did not acknowledge that this change attributes to the distraction of all people entering the building and the harassment of women veterans (Dyer et al., 2021; Klap et al., 2019).

To address this harassment of women veterans seeking care at the VA, Washington et al. (2015) and Moreau et al. (2020) suggested that the VA make changes such as women-only entrances and spaces within the VA or implementing a protocol that will deter men from hanging around the facility. Although the VA added clinics to address the gender gap, there continues to be a lack of services and resources to meet the growing needs of women veterans.

**Gender-Specific Services**

While women are the fastest growing VA healthcare population, they have also been the most underserved in care due to gender biases (Mattocks et al., 2020). Gender-specific services created by the VA were a limited implementation for women veterans to access quality care. A comprehensive health program was implemented for women's veteran health clinics in many VA centers to streamline outpatient care due to the lack of providers in primary care that focused on women's health (deKleijn et al., 2015). Bastian et al. (2014) suggested that to get more knowledge of the women veteran experience is through the lens of the VA providers. The VA does have designated women health providers (DWHP) who specifically work in women's health. According to Bastian et al., a low number of women patients are assigned to DWHPs who have the experience and training to provide better comprehensive care services for women.

In conjunction with not having the proper providers to care for women, there is evidence of a lack of knowledge and women's misdiagnoses (Mattocks et al., 2020). A study by Driscoll et al. (2018) stated that women veterans had a high pain intensity, more pain-related injuries, and mental health modalities stemming from military sexual trauma attached to such diagnoses. However, treatment was lower compared to that of men veterans. Furthermore, the women that experienced such treatment from the VA had a better experience going to a private insurance doctor within the community. With the lack of access to specialty care services, implicit bias was indicated as to why women are treated differently in the VA (Mattocks et al., 2020). The experience of bias is present when women interact with VA staff before, during, and after doctor appointments. Women veterans' perception of the interaction with medical providers is noted as dismissive of pain management, misdiagnosing and treating women equally compared to male patients.

**Congressional Mandates**

There has been growing support for women veterans' equity when addressing the Department of Veteran Affairs barriers, especially for equal access to healthcare for women who have also honorably served in the United States Armed Forces. Congressional support for this issue has been present in many VA implementation initiatives. Since 2009, two prominent bills have passed to ensure that women veterans get adequate care and resources from the VA. These Acts are the Women Veterans Healthcare Improvement Act of 2009 and the Deborah Sampson Act of 2020.

The transparency of the new changes and healthcare gaps that were not meeting the needs of women still had current barriers. These included gender specifics services mirrored by programs in other community healthcare settings such as universities' place-based centers for student women veterans. As the mandate rolled out, the VA pledged its willingness to change practices and accompany women veterans' preferences (Yano et al., 2003). The congressional involvement found the VA lacked communication and targeted campaigning to women veterans. However, other programs, such as the Office of Women Veterans, were developed to explicitly target the women veteran population (Washington et al., 2006).

## Summary

The literature review exemplified the relationship between the VA healthcare system in how they deliver services to women veterans. Historically, many programs and initiatives have been implemented. These issues stem from personal experiences in the military and the male-centric culture the VA has unknowingly embraced over the years. The VA, to some credit, has recognized there is a disconnect between women veterans and many social determinants of health, causing many assumptions within the women veteran population and their reasons why they are uncomfortable with seeking care. However, studies show that proper marketing and education targeted to women veterans and some organizational culture changes can help bridge the gap between women veterans and VA healthcare.

VA initiatives are positive steps for bridging the gap; documenting the lived experiences can help the VA structure proper messaging and programming for women

veterans to better meet their healthcare needs (Silvestrini et al., 2020). The literature highlights the stigma of how women combined views of the military and VA regarding health services. While the study correlated women veterans' identity and VA services, some literature gaps can explore, such as the causality relationships between women and VA providers to understand unique health needs. As this study explores the women veterans' lived experiences, Chapter 3 will discuss the researcher's role, target population, research question, and data collection and analysis.

# Chapter 3: Research Methods

## Introduction

The purpose of this IPA study was to understand the lived experiences of women veterans who had sought healthcare services from the VHA. Historically, women veterans have faced many challenges regarding gender bias and how this barrier has made it challenging to navigate the VA healthcare system (Hirudayaraj & Clay, 2019). The VA has attempted to transform healthcare services for female veterans from a male-centric system. However, the VA has failed to meet the needs of women and will need to address women veterans' unique challenges (Evans et al., 2019). I aimed to understand better the difficulties that women veterans face in obtaining healthcare services from the VA. This study explored how women veterans are subjected to various barriers in obtaining adequate healthcare services and resources delivered by the VA.

The research study captured the lived experiences of women veterans to understand how they perceive healthcare and other support services facilitated by the VA. The research questions were developed to understand how women veterans navigate the complexities of the VHA. The primary research questions were as follows: What are women veterans' lived experiences navigating the VA system? How can women veterans access quality care at the VA? These two questions addressed the healthcare services gap between the VA and women veterans. This chapter includes the following: the research design, methodology, rationale, and the role of the researcher.

## Research Design and Rationale

In this phenomenological study, I used IPA to explore gender equity theory to understand and reflect upon women veterans' unique lived experiences (Cohen et al., 2018). In this study inquiry, I examined lived experiences navigating the VHA by women veterans who had used the VHA for services or resources. Heidegger developed IPA heavily focused on life-world experiences and removed any researcher's perceived bias (Neubauer et al., 2019). This approach served as a helpful lens in understanding women veterans' lived experiences and their health needs documented in their interaction with the VA system. IPA is used to understand meanings and interpret experiences that can lead to existentialist themes in a phenomenon at a given point in time (Tuohy et al., 2013). The IPA approach, as proposed by Husserl, allows for bottom-up description of a phenomenon by those who have experienced it (Brownstone et al., 2018). When adopting this approach, the researcher "put[s] aside preconceived views and biases to gather data based solely on lived experiences" (Pietkiewicz & Smith, 2014, p. 8-9). Pietkiewicz & Smith were building on Heidegger's (1927) theory of phenomenology, using narratives from the layers of human experience to surface awareness through reflecting on their life-worlds (Neubauer et al., 2019).

Finlay (2014) argues on Peter Ashworth's phenomenological theory that embodies participants' experience of selfhood and spatiality in this study regarding women veterans. Using hermeneutics in this study aided me in further inquiring about women veterans and their world. Selecting IPA as the strategy of inquiry for this research study was in complete alignment with capturing lived experience, allowing me to use a

qualitative approach to understand better the women veterans who were part of the research. Suddick et al. (2020) suggested that hermeneutic phenomenological researchers must set aside their prereflective attitude by directing attention and questioning the participants' being-in-the-world experience. Removing biases and setting them aside allows a clearer understanding and information from the participants' world to get a glance into their viewpoint on a phenomenon (Tuohy et al., 2013).

## Role of the Researcher

My primary role as the researcher was to gather, interpret, and analyze data using a qualitative method of face-to-face interviews with women veterans to capture their lived experiences (Suddick et al., 2020; Alase, 2017). As a woman veteran who resides in the Washington, DC area, I used this opportunity to learn more about women veterans and their direct experiences in navigating the bureaucracy of the VHA. I listened to and observed women veterans sharing their interpretation of life-world experiences to give insight into the Washington, DC VA healthcare system.

## Methodology

Husserl's and Heidegger's phenomenology approaches were the main framework for this study. First, according to Suddick et al. (2020), Husserl reintroduced human lived experiences' contribution to qualitative research. Second, Heidegger's theory incorporated Husserl's theory by adding an ontological emphasis on the interpretation of living in the world to understand meaning through someone's world as they experience the world (Suddick et al., 2020). The foundation of an IPA methodology study centers around the lived experience of individuals who have potentially lived said experience.

Phenomenology is the foundation of understanding those living experiences and perspectives (Johnson et al., 2017). I chose this topic as a woman veteran seeking understanding of the experiences of women veterans who had navigated the VHA and how their views could shape organizational change within the VA system and help educate the veteran population on resources and quality of care. Incorporating the IPA approach into this study allowed individuals to tell their stories without judgment or prosecution and find commonality with experiences (Alase, 2017).

## Participant Selection

The participants I recruited came from Washington, DC and surrounding areas with access to the VA healthcare system, including VA medical centers and community-based outpatient clinics. The face-to-face interviews occurred via the Zoom virtual platform and by telephone for those who did not have access to a computer. In the current pandemic, moving the interviews to a virtual platform kept the participants and I safe according to the pandemic health guidelines.

Participants recruited for this study fit the criteria of women veterans of all races and ethnicities received or were currently receiving healthcare from the VHA. Participants were recruited through veteran service organizations and social media, women veteran groups, and centers for women veterans through the Veteran Benefits Administration. The Washington, DC area has a robust network within the veteran community, and its utilization was of paramount importance to the study. Criteria for the study indicated that participants needed to be between 25 and 65 years of age, needed to have served in the military, needed to have a DD-214 form that confirmed their veteran

status, and needed to have sought services through the VHA. Participants could not be serving on active duty or in the reserves at the study's initial recruitment. I contacted the women veterans interested in the study via email and telephone. The women were asked questions from the Criteria Tool (see Appendix A), and if all questions were answered yes, they were asked to participate in the study.

There was no incentive for participation in the study. The sample size goal was between 8 and 12 participants to reach data saturation potentially. Reaching saturation means reaching data redundancy where no new themes are presented using open-ended questions during interviewing (Braun & Clarke, 2021; Guest et al., 2020; Peoples, 2020).

## Instrumentation

The instrument in this study was an interview guide that I developed. Questions were semi structured and open ended (Rubin & Rubin, 2012). Due to pandemic social-distancing guidelines, the interviews were conducted via the Zoom platform and via telephone for those who did not have access to a computer. The questions were open ended to fully capture participants' lived experience of the phenomenon and to allow me to identify themes. First, the questions were in plain language, which the participants understood (Goldberg & Allen, 2015). Second, the questions were read back to the participants. When the interview was complete, I ensured that the information given was accurate according to the participants' experiences and ensured that all information shared would be used only for the research study. Third, asking follow-up questions at the end reduced misinterpretation and confusion in the data provided (Goldberg & Allen, 2015). Usage of the virtual platform and a telephone conference call system allowed me

to record the interviews with the participant's permission. The virtual platform had the advantages of additional noting methods, recording, and playback options to have the information available after the interview was complete. Furthermore, I could have an entire dialogue with the participant as they told their lived experience. Interviews were intimate and personalized.

## Procedures for Recruitment, Participation, and Data Collection

I recruited women veterans within Washington, DC for this study. These women came from all military service branches and showed proof of service through showing the DD-214, a statement of service. Ensuring that the women veterans understood the study involved the use of questions regarding lived experiences navigating the VHA. Second, social media recruitment were in women veterans' groups, as well as by reaching out to women veterans in my professional network and veteran service organizations in the area. According to Creswell (2018), participant selection is essential to capture the lived experience of a phenomenon of interest. Some women shared recruitment information with other women veterans during a pandemic were the best ways to attract participants to this study. Second, this IPA study's sample size should reflect the homogeneity of the potential sample pool (Alase, 2017; Creswell, 2012).

The criteria for participants were as follows:

- women age 25 to 65
- have been honorably discharged from the military
- have a DD-214
- not currently serving on active duty, Reserve, or National Guard

- eligible for VA services and resources
- live in Washington, DC area
- currently seeking or have sought care from VHA

Women veterans who fit the study criteria spoke about their experiences regarding VA Health. I ensured that the environment was safe and comfortable for the participants and that there was little bias or preconceived opinion regarding the VA and affiliated entities (Johnston et al., 2017). Furthermore, actively listening to these women brought meaning to their experience and how that experience can facilitate organizational change and health education for change. These women's stories demonstrate trends in their experience of navigating the VA for healthcare. For the women veterans to feel comfortable sharing their lived experiences, I had to ensure that the environment was comfortable and free of judgment and bias. Creating open-ended and follow-up questions during the interview provided the women the courage to speak up regarding their perceptions of how women veterans had sought healthcare services from the VA.

## Data Analysis Plan

Upon completing the interviews, I organized the notes and data into categories to identify themes and relationships to help formulate conclusions regarding lived experience similarities (Miller et al., 2018). I transcribed the interview recordings and contextualized the data. Alase (2017) explained the importance of identifying interview themes; using the inductive approach helped in finding the relevance within the interviews. The analysis of the interviews helped interprets the data relevant to the

study's objective and meets the goal of showing rich viewpoints that contribute to the phenomenon the participants experienced.

The data software tools used to analyze data in this study were NVivo 12 for Windows and Otter for interview transcription. NVivo is a qualitative analysis tool to analyze open-ended responses in qualitative studies (Feng & Behar-Horenstein, 2019). NVivo is a tool used to code themes and organize the data, as discussed in Chapter 4. Using NVivo helped me identify patterns and themes associated with the research questions. This tool helped with clustering relationships from the data collection to develop themes from the lived experiences.

## Issues of Trustworthiness

To ensure trustworthiness in this qualitative study, there was a balanced understanding of the interpreted data, there were minimal preconceived biases, and the data analysis aligned with the research questions and the proper methodology for this phenomenon. The trustworthiness was ensured by adhering to the participants' authenticity and minimizing my biases and preconceptions (Rodham et al., 2015). According to Rodham et al. (2015), this approach ensures that the researcher highlights the participant's perspective on their lived experience and not their own. Furthermore, the researcher must build a trustworthy environment by being open and transparent with the participant. Simultaneously, in this study, I needed to provide a safe space for the women veterans to be engaging and open with sharing their stories of navigating through the VHA. The study's trustworthiness was ensured by credibility, transferability, dependability, and confirmability.

## Transferability

Transferability within research is using the same methods and outcomes in other populations or settings. The objective of transferability is to use the same results to apply in a broader context to another study or similar population in another time or place (Schloemer & Schröder-Bäck, 2018). I ensured that the study findings were appropriately documented to meet the standard of transferability to similar studies of women veterans. For example, I used saturation of the data collection to reach transferability and kept detailed records of all the events and activities regarding the data collection process for future reference.

## Dependability

Dependability is closely related to doing an external audit on a research study. Dependability involves establishing consistent outcomes and whether the study can be repeated by someone else outside of the study. I took accurate notes that fully told the story of the lived experiences and followed up with questions regarding the data collection accuracy. Second, the method was described so that it could be repeated in another study through developing a roadmap for other researchers to duplicate the method, tools, and research design.

## Confirmability

Confirmability within this study was the objectivity of choosing the best methodology and research design regarding this topic, which was essential in the triangulation between the research questions, the research design, and methods used in this phenomenological study (Korstjens & Moser, 2018). The data collected in a study

should lead to an outcome that the researcher does not control. This was achieved by ensuring that I was neutral from the start to the end of the study, and that everything was documented by a clear paper trail with proper steps in conducting an IPA study.

## Ethical Procedures

For this study to meet ethical standards, I acquired approval from the Walden University Institutional Review Board (IRB). The women veterans eligible to volunteer for this study met the criteria of serving in the military; obtained a DD-214 for service verification; lived in Washington, DC or the surrounding areas; and had benefits eligibility through the VA. After the study received IRB approval, I ensured that the participants completed informed consent forms and that all ethical procedures were met before, during, and after the interviewing process. I kept the information confidential, including call recordings and personal identifiers, and transcribed using identification coding to protect the participants. All information was kept in a locked location and will be stored for up to 5 years before being destroyed by me.

## Summary

This study used an IPA approach as the qualitative framework, highlighting the lived experiences of women veterans navigating their way through the VA healthcare system regarding the quality of care and resources. This chapter highlighted the researcher's role, research design, methodology, and rationale for the study. In Chapter 4, I describe the targeted population demographics and the analyzed data from the interviews with the women veterans.

# Chapter 4: Results

## Introduction

The purpose of this chapter is to highlight the results from the interviews conducted with 12 women veterans. The chapter includes analysis of the data collection and the overall findings. The purpose of this IPA study was to understand the lived experiences of women veterans navigating their way through the VA healthcare system within the Washington, DC area. To achieve this inquiry, I used interviewing via the Zoom platform for collecting data from women veterans. I conducted interviews with 12 women veterans between the ages of 25 and 65 who were honorably discharged and qualified for VA benefits. The following three research questions were used to guide the research: What are the lived experiences of women veterans navigating the VHA? What is considered quality care from the women veterans' perspective when receiving care from the VHA? What are the reasons women veterans do not receive or stop receiving health services from the VHA? These research questions guided the interviews; with the data gathered, I developed themes showing that many of the participants had similarities in their healthcare experiences.

This chapter highlights the viewpoints of the participants and their direct experiences with VA healthcare services. Every participant was able to provide their perception of their account navigating VA healthcare from initial enrollment to the appointment process and community care referrals for certain services. As the researcher in this study and a woman veteran, I was able to present an unbiased approach to actively listen to women veterans regarding their viewpoint on VA healthcare.

## Setting

The study was conducted in the Washington, DC area and included Maryland and Virginia women veterans who received their care from the VA medical center in the area. Due to the Covid-19 pandemic, the study recruitment efforts took place on social media platforms using Facebook groups targeted just for women veterans in the Washington, DC area. Many of the participants were receiving care from the VA at the time of the study. The participants expressed their recent experiences of their interactions with the VA and how those interactions affected their perspective and overall health.

All the interviews took place via the Zoom platform, where the participants were in a quiet place to reflect on their interactions and the feeling within those moments of seeking care. Before and after the interview on the Zoom call, I asked if the participants had questions, reviewed the consent forms, and made them aware that the interview was going to be recorded. Once the interviews were completed, notes were added into the folders, and the interviews were downloaded, ready for transcription.

## Participant Demographics

The goal of the study was to obtain participants who were between the ages of 25 and 65 years; however, the participants who demonstrated interest to volunteer were over the age of 38 years. The use of social media was beneficial because I was able to secure 12 volunteers to participate in the research study. All the women resided in the Washington, DC area, which included Maryland and Virginia (DMV). All the women served in the military and were currently veterans who were receiving or had received care from the VA healthcare system. Seven women served in the Army, four served in

the Navy, one served in the Marine Corps, and there were no participants who served in the Air Force or other uniformed services. All the participants interviewed received their DD-214, were honorably discharged from the different branches of the military and were eligible for VA benefits. Within the DC area, there are multiple VA healthcare centers and clinics. The participants received care from many of the VA medical centers around the DC, Maryland, and Northern Virginia region. I did make some notes and observations along with asking the participants their age and at which VA center they received care.

Recruitment of the participants was solely conducted through social media. Some of the volunteers interested in partaking in the study interview resided outside of the Washington, DC; Virginia; and Maryland area but were not interviewed. Table 1 is a demonstration of the six VA centers of care, and one participant resided in the DC area; however, women veterans may be required to commute to areas outside of the DC area to receive care at the Philadelphia VA Center. Table 1 provides demographic data on the women veterans who participated in this study.

**Table 1**

*Demographic Information*

| Participant | Age | Branch served | VA center | Years in VA Health |
|---|---|---|---|---|
| P1 | 48 | Army | DC VA | 3 |
| P2 | 39 | Army | DC VA | 20 |
| P3 | 42 | Marine Corps | Dumfries VA | 5 |
| P4 | 38 | Navy | DC VA | 12 |
| P5 | 45 | Navy | DC VA | 8 |
| P6 | 40 | Army | Fort Meade | 7 |
| P7 | 45 | Army | Baltimore VA | 4 |
| P8 | 65 | Army | DC VA Satellite Clinic | 22 |
| P9 | 49 | Navy | Baltimore VA | 10 |
| P10 | 50 | Army | DC and Fort Belvoir VA | 2 |
| P11 | 52 | Navy | Baltimore VA | 25 |
| P12 | 42 | Army | Philadelphia VA | 9 |

## Data Collection

Upon IRB approval from Walden University, I was able to begin the recruitment process to obtain 12 participants who met the criteria for this research. The application with the Walden IRB was approved on December 21, 2021. The purpose of the IRB is to ensure that research methodology and research design are in alignment with the university's ethical standards. There were no partners used in this study to assist with the study participant pool. All recruitment was performed through the use of the Facebook social media platform. By utilizing a criteria tool (Appendix A), I was able to determine whether or not the participants met the eligibility requirements to be part of the study. The research design consisted of a semi structured interview format using specific questions to guide the study (Appendix B). The benefit of conducting a qualitative study was that it made it possible to capture the lived experiences of the women veterans and how they perceived health services provided through the VA healthcare system (Brownstone et al., 2018).

Once I determined each participant's eligibility to be part of this research study, each participant was provided with the consent form to review and respond to with an email specifically stating, "I do consent to the interview." Once the consent was established, appointment times were scheduled and communicated to each participant to schedule an interview using the Zoom format. As part of ensuring the integrity of the data collection process, I informed each participant of the possibility of a second interview.

All the participants were women veterans, who were willing volunteers in sharing their perception of how they navigated the VA and the potential reasons why women

veterans have stark differences in experiences with the VA compared to other veterans. I was engaged in hearing these perspectives because it provided me with a different perspective through the lens of being patients within the VA healthcare system. The interview consisted of 15 specific questions that were used to understand the experiences of women veterans in relation to VA healthcare services and how they perceived its value of care.

All the participants were agreeable to recording the interview session, which allowed me to transfer the data to be transcribed in NVivo and transfer the transcription into Otter as part of the data analysis process. All interviews' transcriptions were transferred to a removeable USB and stored in a locked box in my home office, which was within the Walden University IRB regulations that were approved.

## Data Analysis

There was a total of 12 interviews that captured the experiences of women who were currently enrolled in VA healthcare. The steps for data analysis began with screening the participants with the criteria tool. If a participant met the criteria to proceed with the interview, I then sent the participant the informed consent form and asked the participant to read the form and send it back via email to indicate that consent was given for the interview. When the interviews were transcribed, themes emerged that were common across all the women. The three research questions were addressed through 15 semi structured questions that were answered by the participants. Using the IPA strategy of inquiry approach allowed me to reflect and understand the participants' perspective on their care and how they truly felt through a patient's lens. This IPA approach used the art

of reflecting and active listening when asking the questions that made the participants feel comfortable and open with their responses.

I then documented that the participant was ready to schedule an interview, offering time slots that were convenient for the participant (People, 2020).

The second phase of the data analysis involved developing themes from the 12 completed interviews. Once the trends were categorized, my notes and observations of the participants were taken into consideration. This phase of the research allowed me to connect between the themes within the interviews that had identifiable similarities of experiences with the VA. In the third phase, I contacted the participants to ask follow-up questions regarding the locations, if they had questions, and the timeframe when they received care from the VA. The participants had no follow-up questions for me and no information to add to their interview.

As explained in Chapter 3, NVivo software was proposed as the tool to be used for data analysis. Once the interviews were complete, I then transferred the interviews to transcriptions via NVivo and Otter software. The Otter software was better for transcription and easy to transfer into the NVivo software. Furthermore, I also kept records of the transcriptions and the audio recordings from the Zoom platform. Other programs that were used for coding and keeping notes during the interview included Microsoft Excel. These tools allowed me to conduct the coding process, develop emerging themes, and determine how to group those themes to correlate with the study's research questions. Once the coding was complete, there were 10 themes that were

identified, which included prolonged appointments, gender services availability, and interaction with VA medical staff.

## Evidence of Trustworthiness

To establish trustworthiness within the findings of this study, transferability, dependability, and confirmability were verified through demographic questions such as questions ensuring that the participants were veterans and had served in the military and as a result had a DD-214 or equivalent that verified service. The establishment of credibility was having participants who received treatment from different VA centers in the DC area. Those centers included the Washington, DC; Baltimore; and Fort Belvoir VA medical centers. I sought to capture a diverse group of participants from different branches of service and different eras of service. The data results showed viewpoints and experiences with similarities between military culture and veteran culture for women veterans receiving healthcare from both medical systems. Many of the women were over the age of 35 and had different experiences with healthcare in the military but similar experiences with the VA regardless of the location in the Washington, DC area.

Before the interview, during the interview, and after the interview, the same questions were asked for clarification that captured the confirmation of correct information. This step was very important to ensure that all demographic and follow-up information was properly recorded to for each participant. Each participant had separate folders with all information that was collected before, during, and after the interview.

**Transferability**

Within this study, transferability gives credibility to the findings that can be applied to similar lived experiences in other populations (Peoples, 2020). In this case, I sought to ensure proper demographic information on the study participants and detailed information concerning the themes, settings, and study findings. Furthermore, I safeguarded the information collected as accurate to keep the authenticity that captured the full voice of the participants during their interview.

**Dependability**

Dependability measures within the study included follow-up questions and interview interpretations from the participants, ensuring that the transcriptions were clear and concise, and that the data reflected that of the participants. I followed the outline of Chapter 3 to keep with the proposed layout and method design when Chapter 4 was developed. This included the audit details of the methods and processes completed during this study.

**Confirmability**

Confirmability is grounded in the interpretation that study data are only found in the findings and not from the researcher's own viewpoint or inserting biases into the research (Nassaji, 2020). Within this qualitative study, I ensured the data led to the conclusion and dissociated myself from inserting opinion.

Confirmability also shows if the study can be replicated in another study, or the findings 'accuracy can be confirmed by others outside of this study. In this case, I

ensured there was a trail of accurate documents and that note taking was thorough, in case there was an evaluation of the findings.

## Results

This phenomenological analysis inquiry was conducted to examine the lived experiences of women veterans navigating through the VA healthcare system and their perception of the quality of care received. The participants were receiving care from many of the VA centers in the Washington, DC area. The participants expressed the location of the VA center from which they were receiving or had received care. The data analysis highlighted the themes. Themes were grouped based on words, phrases, and types of services. Table 2 shows the research questions correlated with emerging themes.

**Table 2**

*Research Questions and Emerging Themes*

| Research questions | Emerging themes |
|---|---|
| What are the lived experiences of women veterans navigating the Veterans Health Administration? | Perception of VA<br>Provider empathy<br>Level of comfort |
| What is considered quality care from the women veterans' perspective when receiving care from the Veterans Health Administration? | Women clinic<br>Community care<br>Information sharing |
| What are the reasons women veterans do not receive or stop receiving health services from the Veterans Health Administration? | Communication<br>Delayed appts<br>Perception of overall health<br>Interactions with VA |

**Research Question 1: What Are the Lived Experiences of Women Veterans Navigating the Veterans Health Administration?**

What are the lived experiences of women veterans navigating the Veteran Health Administration? Three themes were categorized to answer RQ1, those themes were (a) Perception of VA, (b) Provider Empathy, and (c) Level of Comfort. Table 2 highlight which participants and the frequency of the theme to support RQ1. These themes were captured by thoroughly reviewing and focused the narratives of the participants' interviews. Opened-ended questions from the interview guide that would help shape the lived experiences of women veterans with VA Health.

***Theme 1: Perception of VA***

Majority of the participants experiences with the VA similar in the concerns and why there are skepticism on continuing to receive care and resources from VA healthcare. However, there were a couple of participants, who expressed positive outcomes with their care with the VA.

Participant 2 stated, I've been able to get care at the VA, and access all my records. Overall, I had pretty good experience with VA.

Participant 3 rated experience with the VA 8 of 10 for services.

Participant 4 felt the VA can hire more medical providers to have more services available.

Participant 6 stated that most veterans deal with the VA because there is no other choice to get services elsewhere. Felt that those veterans who are 100% disable should be entitled to VA services and resources.

Participant 7 stated health problems hasn't been resolved with the VA.

Participant 8 added that VA medical centers are different in services available but currently receiving good outcomes from the VA.

Participant 10 disclosed that men do not get pushback like women. Women healthcare issues are not taken seriously. Felt combat related issues have precedence over any women' health issues. There is a lot of red tape into the VA for appointments and for emergency room service.

Participant 12 mentioned the medical staff does not treat patients but instead medicate without proper diagnosis. Felt that women veterans do not receive the same treatment as men veterans. Felt that dealing with the VA is overwhelmed with the lack of care and not listened too regarding health concerns.

***Theme 2: Provider Empathy***

Many of the participants mentioned they felt VA providers lacked empathy with patients, especially women. They felt they were not taken serious regarding the health or treatment plan. The medical provider did not provide quality of care in which patients' illnesses have gotten worse over time.

Participant 1 mentioned, had a consultation about my feet because I'm like, you know what, it's really, difficult for me to walk, it's getting, you know, it's getting worse. My feet are hurting all the time. I'm having neuropathy in my feet all the time. He sent

me some data. I mean, that was it. It was it was a phone console, a phone appointment. He said, hey, everybody's feeling this way. I'm like, well, I'm talking about everybody, though. I'm kind of just about myself. I'm like, he's like, well, yeah, everybody's feeling this way. Because now they're going back to work and different body.

Participant 1 farther states parts are, you know, being reengaged I'm like this, okay, but that's not looking into the problem, like, okay, so he sent out some cream pain medication.

Participant 2, My psychiatrist kept telling me, I needed medicine, I needed meds. Well, I couldn't even get in touch with a psychiatrist, my psychiatrist. It took about four months to get in touch with my psychiatrist.

Participant 4 stated, they always treat it with the most minimal measures that they possibly can. Um, and then, you know, somehow, my primary will wrap it back around to my mental health. But during the mental health treatment, she kind of wrapped it around to, oh, well, you know, your body changed your unhappy bubble, you know, and made it like a physical thing.

Participant 6 added, in fact, they scheduled an appointment for an IUD. When I had told them that, no, I don't want an IUD. Why are you guys forcing this down? They said they schedule she scheduled a consultation anyway, for an IUD.

***Theme 3: Level of Comfort***

Some of the participants expressed issues with their comfort levels when visiting VA centers and feel the medical staff lacks compassion. Furthermore, participants stated the VA has the same type of male centric environment they experienced while in the

military. Some of participants stated they felt uncomfortable at times visiting the VA for services.

Participant 1, stated “Prior to COVID I would go to the VA and, and it's just people hanging around out front is just not really a comfortable, just, I don't know, it just, I can't really explain it, but it's not really, I don't feel comfortable going.”

Participant #1 further explained their level of comfort by stating, “Right now I can't really think of anything other than the VA hospital NVC is not a warm and welcoming atmosphere period. I get anxiety just going into the building”.

Participant 10 mentioned, “it's the red tape like honestly, I don't really even know how to walk in for an emergency to the VA, that's only opened between eight and four, I know I'd have to go to the nearest military hospital.”

Participant 1 stated “I was not going to work with men. That was the only thing I didn't care if there was a nurse practitioner, there was a doctor or psychiatrist wherever, wherever they needed to be. They just had to be female. They had to be a woman they all are female providers. So, when I go in the room, not only was there no women, and I specifically said there has to be a woman in this room. They brought in three men”.

**Research Question 2: What Is Considered Quality Care from the Women Veterans' Perspective When Receiving Care From the Veterans Health Administration?**

RQ2 was, what is considered quality care from the women veterans' perspective when receiving care from the Veteran Health Administration?

### *Theme 4: Women's Clinic*

The participants were asked about their experiences with the VA women's clinic. There were mixed experiences amongst the participants regarding the care received within the clinic.

Participant 1 stated, um, so all my all my appointments are in the women's clinic, I've had that work done. I have no issues with the women's clinic. But plan on switching to another women's clinic if I can change my doctor.

Participant 2 stated, I'm getting ready to go to an OB GYN that I selected your TRICARE because I no longer will leave This to my primary over at the VA, for I haven't been to the women's clinic, so I don't know what they have what services they offer at the VA clinic. I mean, the women's clinic.

Participant 6 noted to then to be seen on the on the woman side. I think I went to GYN one time. I tried to go more than that. And they were like, oh, well, your last Pap was like, you know, within five years, so you don't qualify to be seen again.

Participant 8 stated, I guess I was a little disappointed in that when I first call to get signed up with the become a part of the women's health clinic where they accept new patients' intake was closed to new patients.

### *Theme 5: Community Care*

Many of the participants had to receive referrals out in the community because the VA did not have the services available due to lack of providers, or appointments were not available for the patient. Such services such as lab work, mammograms, women's health services, and oncology. The Mission Care Act was passed to ensure that any service that

could not be provided in network was referred to the community access to patient care services.

Participant 1 noted, I had labs done, and neither time did they follow up with those lab results, um, one of the lab results required additional testing. Also, I end up receiving a bill for the services and what the bill wasn't really the VA fault. It was, I believe it was it was the place the imaging office but just having to fight for to get the VA to cover that bill is just because it was coded incorrectly.

Participant 5 added I was due for a mammogram and their machines were down at the VA. And so, I had to go to like community radiology. Oh, but like, the doctor didn't send the referral in, and I had to go back and forth between the VA and community radiology which was, you know, a headache when I don't feel like I should have because you know, your machines are down. So it's not my responsibility to figure out this process.

Participant 6 stated, Um, even when you go care in the community, you're waiting, you know, two to three months to be seen.

Participant 7 added, I think all the services I can get in the community, I can get through the VA as well. Quality might be different. The quality is probably my issue the quality.

Participant 9 noted, and then that took like a month to lay you got to wait for 30 days to see if the VA is going to have any openings. And then from there you got to research who's out in town to where you can go that accepts the Community Care.

### *Theme 6: Information and Education Sharing*

Many of the participants stated it would be great to receive information around health workshops, events, and valuable information just for women veterans can help with getting better educated on healthcare services and resources. Other participants mentioned having education around healthy lifestyle, nutrition and other wellness resources will help with their overall wellbeing. Information sharing through localized newsletters, more advertising of health programs and information other than pandemic would be helpful for overall health.

Participant 1 stated that newsletters should give me some of the ways to preventive care versus, um, I think information on preventive care would be beneficial to me. Like, what are the things that you should eat or should take or should do? Um, what are some of those things that can build your immune system? So I think things like that would be beneficial.

Participant 2 added, Um, yes, they give information as far as like the newsletter, as far as like what services they provide, you know, like, Hey, we're running like a hearing clinic on these days and this time if you need like variable benefits or want to find out about what your benefits are like they provide I think the newsletter provides like good information.

## Research Question 3: What Are the Reasons Women Veterans Do Not Receive or Stop Receiving Health Services From the Veterans Health Administration?

RQ3: What are the reasons women veterans do not receive or stop receiving health services from the Veteran Health Administration?

### *Theme 7: Communication*

Many of the participants felt communication between patients and the VA medical staff is ineffective at communicating properly. Participants mentioned the lack of communication regarding medical follow-ups, important medical updates, or appointments.

Participant 11 stated, “found out was diagnosed with diabetes but never received a call from primary care doctor or their staff to inform the participant of the medical results, instead found out by logging on to the VA patient portal to find out the diagnosis and that medication was prescribed but not notified.”

Participant 1 mentioned the medical staff at VA has never contacted directly regarding medical information. Has called the primary care office, but never has received a callback regarding follow ups with medical updates.

### *Theme 8: Delayed Schedule Appointments*

Majority of the participants highlighted they had problems with getting appointments and wait times for those appointments are over 3 to 6 months away or appointments were unavailable.

Participant 1 stated there were no appointments available to be seem by their primary care provider and the pandemic made scheduling appointments difficult.

Participant 2 stated “all the appointments were between 3 to 4 months out and was thankful the treatment needed was not urgent. “

Participant 5 mentioned needed to cancel an appointment and the front desk stated all scheduled follow up will be also cancelled. Felt the staff was very insensitive and felt like the staff bullied into keeping the appointment.

***Theme 9: Perception of Overall Health***

Some participants believed their overall health has declined since receiving care from the VA. Participants mentioned the lack of communication, longer wait times for appointments and not being informed early on regarding medical conditions it has contributed to decrease in health.

Participant 12 mentioned within the last 10 years of receiving treatment at the VA, overall health has declined because of the level of care, and changes to the lifestyle such as development of medical conditions due to side effects from medication.

Participant 4 added did not know health was declining because of multiple surgeries, wait time for referrals to community care due to the lack of providers in specialty care at the VA. Secondly all medical diagnoses are not documented in the medical record. Due to the medical conditions, doesn’t feel heard or involved in own care decision making.

***Theme 10: Interactions With VA***

All participants shared an experience of different interactions with the VA staff regarding their care. Many of the participants felt certain staff had some effect on their health and access to services. The negative interactions included the way many of the VA staff spoke to patients in a demeaning manner, overlooking the concerns of the patient such requests to have female staff in the exam room during visits and longer than normal wait times at the time of appointment.

Participant 1 mentioned, “I will say that I’m not I’m not impressed with some of the things that they do. For example, when I first retired and I went to seek care, I had some blood work drawn. And they don’t, or they didn’t in my case, like, twice I had labs done, and neither time did they follow up with those lab results, um, one of the lab results required additional testing. And the only way I found that out, it’s because I was looking at my records”. Participant also stated that “took me about three years to get into mental health”

Participant 4 stated, “more on the admin side of the house, once I get to the destination where they’re taking care of me, I have had the attention that the issue requires, but getting there, getting them to take you seriously, it has been a bit of a challenge”.

Participant 9 expressed; “many medical staff don’t listen to what you are talking about. They are stuck on this treatment plan, and they’re not listening to what that treatment plan is doing. So, when I go in the room, not only was there no woman, and I specifically said there must be a woman in this room. They brought in three Damn man. I

said, what's going on? What was what did they call them? A chaperone. But I'm just saying for lack of a better word is chaperone. Where's the lady chaperone? We don't have one".

Participant 7 conveyed, "as far as on the active-duty side, I don't feel like I got quite the same treatment on the VA side". P8 also stated "I got a new therapist. I'm with the VA. They're like, No, she's a specialist. She, this is what she deals with, you know, sexual assault, she's, you know, and I have no personal issues with her. But, you know, professionally, I don't think that we were compatible, or that she helped me in any way.

## Summary

In this chapter I highlighted the aim of the usage of interpretive phenomenological analysis that focused on lived experiences of women veterans and their detailed account of navigating the VA healthcare system. To capture the stories, each research question with the best identified and relatable answers from the participants. IPA help with results to the three research questions which the interview questions were tailored to these specific questions to understand the experiences of the participants. There were multiple themes that emerged during this period. The major theme was overall perception of the VA through discussion of appointments, communication issues and interactions with the medical staff when navigating through multiple processes regarding quality of care. Many of the participants within this study had very similar stories about their perceptions with the VA of feeling their inputs do not matter when it comes to their overall patient experience with the VA.

This chapter's findings were to identify the themes from the stories of the participant of their perceptions of how they view navigating through the VA health system in the Washington DC area. Their viewpoints were heavily supported by personal interactions with the VA and the outcomes of such interactions. In this next chapter I will interpret the themes, the ways in which this information can be used for further research and the limitations of this study.

# Chapter 5: Discussion, Conclusions, and Recommendations

## Introduction

The purpose of this qualitative phenomenological analysis study was to explore the viewpoints of women veterans regarding their experiences navigating the VA healthcare system. To this research, I managed to recruit 12 women veterans who resided in Washington, DC and the surrounding areas who used VA health centers for their healthcare needs. These participants were essential for the research as they were able to share their perceptions about various healthcare services provided by women's healthcare clinics. In addition, the participants reflected upon their individual experiences with appointments and interactions with VA medical and support staff. The women veterans shared their disappointment about the lack of communication by the VA in terms of how they communicated about services specific to their health needs in various channels including newsletters, patient portal updates, and follow-up care with their healthcare practitioners.

There has been previous research conducted within the VA regarding healthcare services for women veterans, but there is little evidence concerning lived experiences from women veterans' viewpoint in navigating through the VA healthcare system. In correlating the evidence from the viewpoint of women, research has indicated that women veterans feel isolated, which has created barriers to care through the VA that are keeping women from receiving quality care (Brownley & Dunn, 2021). The participants' experiences can shape how implementation of better services and access to care for women's health needs within the VA can help in future research and programming

(Marshall et al., 2021). As the women veteran population continues to grow and members need access to care through the VA, there are some practices that must change to serve the unique needs of women. The participants in this study expressed how the VA medical system is not designed to meet their specific healthcare needs; therefore, restoring healthcare equity for women veterans is essential.

## Interpretation of the Findings

The findings of this study provided me with a greater understanding of how women veterans view their unique experiences navigating through the VA healthcare system and interacting with VA medical staff within VA medical centers and clinics in the Washington, DC area. The research questions that were explored in this study were as follows:

RQ1: What are the lived experiences of women veterans navigating the Veterans Health Administration?

RQ2: What is considered quality care from the women veterans' perspective when receiving care from the Veterans Health Administration?

RQ3: What are the reasons women veterans do not receive or stop receiving health services from the Veterans Health Administration?

When addressing the research questions, I found overlap in the perceptions of the women veterans, who felt there were inequalities in access and quality of care when getting treatment through the VA. Many of the women veterans interviewed had similar views on their overall health correlating with the disparities they had faced when seeking treatment with the VA. These similarities were identified throughout each interview with

the participants, who shared how they were having difficulty connecting with medical staff, having proper follow-up regarding their medical information and condition, and feeling uncomfortable within the medical centers and clinics. Brunner et al. (2019) argued these views correlated with previous studies that revealed how gender-based services were needed for women veterans at the organizational implementation level, as suggested by medical staff. Boros and Erolin (2021) discussed a large gap in the research regarding women's services and women not receiving equal healthcare.

I explored the participants' views through how they answered the questions, which addressed this study's three research questions. The data collection process developed 10 themes that captured the lived experiences of the women veterans who participated in this study and how these experiences correlated with current research. The participants' responses highlighted interactions with VA staff, overall health, limited access to proper treatment and care, prolonged appointments, and lack of communication regarding medical information. Similarities in participants' responses were present; even though the participants were attached to different VA center/clinics within the Washington, DC area, they had similar experiences with the VA system and medical staff interactions.

The themes that developed from the interview analysis were correlated with the study's research questions, to make sense of the experiences highlighted from the participants. In the next section, I explain some of those themes, which reflect consistent issues and barriers to women veterans receiving quality care from the VA.

**Perception of Veterans Affairs**

Newins et al. (2019) and Thomas et al. (2018) stated that women veterans have a perception of the VA that has caused many patients to seek services outside of the VA healthcare system for their health needs. Analyses of the interviews within this study indicated that participants' perceptions were like what previous studies have shared. The perception of the VA was a clear theme that emerged during the interview process with the participants. Many of the participants had negative or adverse experiences that shaped their views. Most of the participants felt that there should be more services geared towards women, that there needed to be an efficient communication system in place to get information to patients in a timely manner, and that there was a need for better training for the medical staff that was targeted just to treating women veterans. Some of the respondents did express that there needed to be more information sharing regarding medical concerns and programs that were available for patients.

**Provider Empathy**

Women veterans observed deficiencies in the level of provider empathy. Provider empathy with patients is an important factor with a correlation with positive patient outcomes and satisfaction. Many participants in this study had similar responses to VA medical staff lacking provider empathy, which had caused many to reconsider receiving further care from the VA healthcare system. The responses were aligned with other research that has examined empathy with positive quality outcomes for patients. Than et al. (2020) explained the gender sensitivities with women veterans and the result of care due to gender inequities that were caused by lack of training for medical staff to the

female patient population that sought care at the VA. Furthermore, lack of empathy has led to medical errors and miscommunication regarding patients not following medical advice or returning for a follow-up visit with the same provider (Hannan et al., 2019). Some of the participants mentioned certain concerns, such as requesting a woman provider or nurse in the same room and having a provider disregard the request. This participant stated that she was less likely to go back to the provider and reported the incident to the VA patient relations department to check on why the request was disregarded and not documented correctly in the patient notes.

**Women's Clinic**

The research disclosed how some of the participants were not aware that a women's clinic was a service the VA provides specifically for women veterans to address their unique healthcare needs. However, some of the participants felt the women's clinic lacked the staff to schedule and keep appointments or that all services were required to go through the women's clinic before being scheduled outside of the clinic for other services such as mental health. The primary concern for the majority of the participants in this study regarding the women's clinic was the availability of a women's clinic primary provider, but as stated, two of the clinic locations in the area are currently not accepting new patients. With this barrier, the participants stated they had to get a referral for services in the community to take care of their health needs.

**Level of Comfort**

During the interviews in this study, many of the participants shared their level of discomfort in receiving any services from the VA healthcare system. The research

revealed how within the women's clinic, some women did not feel safe or comfortable navigating to other clinics inside the medical centers. According to Moreau et al. (2020), some women veterans felt unwelcomed at the VA due to the dominant presence of men, and the VA staff did not decrease such behavior by other patients and visitors to the medical center. Moreau et al. (2020) further noted in their study that the overall women's experience of care at the VA is just as important as men's experiences, and that a hostile environment decreases the quality of care while enhancing barriers to care for women veterans. In another study, Dyer et al. (2019) shared that stranger harassment in medical centers interfered with healthcare equity, leading women veterans to delay or forego healthcare services due to strangers causing a hostile environment in which to receive care.

**Veterans Affairs Operational Issues**

Several of the themes fell under VA operational issues; these themes were communication gap issues, delayed appointments, and staff shortages. During the interviews, many of the participants voiced concerns regarding lack of communication, which had caused issues with patients receiving vital information. For example, one participant stated that an explanation of results was not relayed to her in a timely matter. Previous studies have highlighted a lack of medical staff and training that has caused this type of issue to reoccur.

**Perception of Own Overall Health**

Many study participants felt that their health had declined over the course of receiving care from the VA for their healthcare and treatment needs. The reasons for their

decline in health, from the participants' perspective, related to gender bias, delayed appointments, lack of empathy, misdiagnosis, or lack of follow up regarding health status by the VA. Participants expressed those efforts to meet their healthcare needs had been lacking at the VA, where there had been issues with how the medical staff perceived women veterans. In a study by Mattocks et al. (2020), it was concluded that some women felt their healthcare was disregarded by medical staff. Outside of the VA healthcare system, studies have documented differences in how women are treated in the healthcare system by providers.

## Limitations of the Study

The main limitation of this study was that it was limited to a specific geographical area. The study did not include women veterans who resided outside of Washington, DC and surrounding areas. The study focused specifically on women veterans who received healthcare services at VA healthcare clinics and did not include patients of other medical facilities. Another limitation of this study was that the interviews were held on a Zoom meeting platform; therefore, the participants were confined to a virtual platform that provided an atmosphere of comfort to interview for this study. Due to the coronavirus pandemic, the pool of participants was limited, as recruitment occurred online via Facebook women veterans' groups. During the interviews, the VA centers that were mentioned were the Baltimore VA Medical Center, DC VA Medical Center, Fort Belvoir VA Outpatient Clinic, and Fort Meade VA Outpatient Clinic; therefore, the study did not include other VA clinics. Last, the study was limited to women between the ages of 38 and 65 years and did not include women who were between 18 and 37 years of age.

## Recommendations for Future Research

Phenomenological analysis was selected for this study because there was a lack of studies that captured the lived experiences of women veterans currently receiving care from the VHA. The findings highlighted in this study gave a better understanding of the gaps and health inequities that women face in trying to receive quality care from a male-centric healthcare system. The purpose of this study was to bring awareness from the perspective of women veterans who currently receive care from the VA about how processes can improve across the medical centers in the DC area. With this information, VHA decision makers may potentially see that there is a gap between the patients and the perceived care that is being given through the VA.

Previous research regarding women veterans and quality of care within VA medical centers has a complex history. In recent years, studies have shown some improvements of services for women veterans. Marshall et al. (2021) emphasized the increase in women veterans who receive care from the VA, as well as the implementation of nationwide comprehensive primary care and gender-specific care that will decrease the barriers to care across the VA healthcare system.

The current study had limitations due to the number of participants, location, and demographic parameters. Similar studies should be conducted with other VA medical centers in other regions for a longer period on a rolling basis, with the VA gathering information from patients to ensure that women veterans are being heard and their suggestions for health equality are taken into consideration when making operational changes within the VA healthcare system. Further research should involve built-in

touchpoints with women veterans to get real-time data while interacting with medical staff during their care. For example, there is a need for more research regarding the continuum of care with the women's clinic, referrals for woman-specific services, and medical staff experiences from the provider viewpoint to understand the quality of care that women veterans receive when navigating through the healthcare system.

## Social Change Implications

This IPA qualitative study captured the lived experiences of women veterans, focusing on their perspective on quality-of-care standards for women within the VA healthcare system. The interview questions were correlated to the study's research questions to understand women's experiences with receiving care and interacting with medical staff for their healthcare needs. The main themes that emerged from the interviews, such as lack of staff and inefficient appointment times, addressed the research questions on why women veterans are hesitant in continuing or seeking services from the VA for their healthcare needs. The study findings supported previous research on the equality of care status that women veterans face within a system that they perceive as a male-centric system.

The study may provide insight into making change regarding operational processes to measure the quality of services for women. Second, conducting more qualitative research studies in the future and focus groups with a targeted audience of women veterans at other VA medical centers to understand the totality of access and similar issues that may be prevalent in other regions. The information can be used to help VA leadership and staff to develop trainings, professional development, and hiring

practices to expand on the increase in the women veteran patient population, which is growing rapidly. Furthermore, such information can be used to develop more marketing and newsletter tools that will interest women veterans in enrollment and increased engagement with VA health programs and services. While there is a designated Office of Women Veterans within the VA, it may be necessary to give more control to the department to ensure that women veterans have increased equality in research, operational processes, and positive interactions with medical staff.

The viewpoints of the study participants highlighted that they wanted to feel heard and included in their care when receiving care, services, and treatment with the VA, and that lack of feeling heard and included had caused many to consider seeking care outside of the VA healthcare system. Many felt that their health was declining due to the care received from the VA. Bridging gaps so that women veterans felt welcomed, respected, and heard was a main priority for many of the participants interviewed. By listening to their story, it may be possible to better provide efficient needs assessments for services and tailored care for women veterans when collaborating with medical staff regarding their overall well-being.

## Conclusion

This study gave me insight into the lived experiences of 12 women veterans sharing their views on navigating the VA healthcare system. This process has shown that while women have rightfully served in the military and successfully transitioned, they no longer feel secure in having equitable access to quality care. Many of the women who participated in this study felt that their overall health had declined since they had sought

out healthcare services from the VA. Previous studies have shown that there are many disparities in the VA healthcare system when it comes to providing care for the nation's veterans. Many VA medical centers and clinics cannot provide certain levels of care because some locations do not have a designated women's clinic to serve women's unique needs. However, the VA has made great strides in operational processes to implement quality and specialty care to the growing population of women veterans over recent years.

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Appendix A: Study Participation Criteria Tool

Please answer Yes or No to these questions. To proceed with the interview, you must answer Yes to each criteria question.

| **Criteria Questions** | **Yes** | **No** |
|---|---|---|
| A. Do you have a DD-214 Certification of Discharge from Active Duty | | |
| B. Do you qualify for Veteran Affairs benefits? | | |
| C. Do you reside in the Washington, DC area and/or surrounding areas? (MD/VA) | | |
| D. Are you at least 25 years of age? | | |
| E. Do you agree with being recorded during this interview? | | |
| **Does the participant meets/does not criteria questions for this study?** | | |

Appendix B: Semi structured Interview Guide

Date_____

Interviewee_____

Introduction: Thank you for participating this research study focusing on women veteran's living experiences with VA healthcare.

1. Tell me about yourself.
2. How was your experience while serving the military as a woman?
3. In your opinion, how has your health been since the transition from the military to VA healthcare?
4. Do you think your health has it improved or declined since being out of the military?
5. Are there specific healthcare issues that you see as being unique as a veteran and a woman?
6. What are the main factors when seeking a doctor for your needs?
7. How has your experience been with VA healthcare?
8. What is your experience navigating the Veteran Health Administration?
9. What are some challenges you have seen that have affected your perception of care?
10. What are some of the services that you receive from the VA?
11. Do you receive information such as newsletters and current events going on at your local VA center?
12. What type of VA information would be beneficial to you?
13. What are some services and resources the VA can improve on to make your experience better?

14. If you do not receive care from the VA, why is that?
15. What services do you receive from community care that you cannot receive at the VA?
16. What has made you hesitate about seeking care from the VA?
17. Is there anything else you would like to share that has not been shared earlier?

**Post-Interview Steps**

- If you have any questions about this interview, you can contact me at Candance.Willett@waldenu.edu
- I will start analyzing and transcribing the interview. Are you willing to provide your contact information in case I do have follow-up questions?
- Please be aware that this interview will be kept confidential, and you will be assigned a unique number instead of your name or other identifiers.
- You are available to request a copy of this study at its completion.